AMENDED IN SENATE APRIL 3, 2001

SENATE BILL No. 117

Introduced by ~~Senator~~ *Senators* Speier *and Dunn*
(Principal coauthor: Assembly Member Alquist)

January 24, 2001

An act to amend ~~Section~~ *Sections* 1371.35 *and 1371.4* of the Health and Safety Code, relating to health care service plans.

LEGISLATIVE COUNSEL'S DIGEST

SB 117, as amended, Speier. Health care service plans: reimbursement of provider claims.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the regulation and licensure of health care service plans by the Department of Managed Health Care and makes the willful violation of its provisions a crime. The act ~~includes provisions pertaining to a plan's payment of provider claims for the provision of emergency services and care, as defined, that require, among other matters,~~ *requires a plan to reimburse providers for emergency services and care provided to its enrollees and authorizes the plan to delegate this responsibility to its contracting medical providers. The act also requires* a plan to pay the claimant the greater of $15 per year or interest at the rate of 15%, as specified, if an uncontested claim *for the provision of emergency services and care* is not reimbursed ~~by the plan~~ within a prescribed time period. ~~These provisions authorize a plan to assign to any entity its responsibility to make these payments.~~

This bill would ~~allow a plan to assign only to an independent practice association or to a medical group its responsibility to pay claimants this fee and would~~ provide that the alternative fee of $15 that the plan may

be required to pay a claimant for failure to timely pay an uncontested claim, is assessed for each 365-day period, or portion thereof.

The bill would prohibit a plan from assigning ~~to any entity~~ the responsibility for payment of a claim for emergency services and care ~~but would authorize a plan to assign to an independent practice association or to a medical group responsibility for payment of emergency and on-call physician services provided in a hospital emergency department if the IPA or group demonstrates to the Department of Managed Health Care that it pays those claims on a timely and fair basis. The bill would require the department to adopt regulations specifying this standard~~ *to its contracting providers unless the provider is able to demonstrate to the department an ability to pay claims for these services to both contracting and noncontracting providers of emergency services and care*.

Because this bill would specify additional forms of prohibited conduct under the ~~Knox-Keene Health Care Service Plan Act of 1975~~ *act*, the violation of which would be punishable as a criminal offense, it would expand the scope of an existing crime, thereby imposing a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 1371.35 of the Health and Safety Code is amended to read:

1371.35. (a) This section shall apply only to claims for services rendered to a patient who was provided emergency services and care, as defined in Section 1317.1, in the United States.

(b) A health care service plan, including a specialized health care service plan, shall reimburse each complete claim for emergency services and care, or portion thereof, whether in state or out of state, as soon as practical, but no later than 30 working

days after receipt of the complete claim by the health care service plan, or if the health care service plan is a health maintenance organization, 45 working days after receipt of the complete claim by the health care service plan. However, a plan may contest or deny a claim, or portion thereof, by notifying the claimant, in writing, that the claim is contested or denied, within 30 working days after receipt of the claim by the health care service plan, or if the health care service plan is a health maintenance organization, 45 working days after receipt of the claim by the health care service plan. The notice that a claim, or portion thereof, is contested shall identify the portion of the claim that is contested, by revenue code, and the specific information needed from the provider to reconsider the claim. The notice that a claim, or portion thereof, is denied shall identify the portion of the claim that is denied, by revenue code, and the specific reasons for the denial. A plan may delay payment of an uncontested portion of a complete claim for reconsideration of a contested portion of that claim so long as the plan pays those charges specified in subdivision (c).

(c) If a complete claim, or portion thereof, that is neither contested nor denied, is not reimbursed by delivery to the claimant's address of record within the respective 30 or 45 working days after receipt, the plan shall pay the greater of fifteen dollars ($15) per each 365-day period, or portion thereof, or interest at the rate of 15 percent per annum, each of these time periods beginning with the first calendar day after the 30- or 45-working-day period. A health care service plan shall automatically include the fifteen dollars ($15) per each 365-day period, or portion thereof, or interest due in the payment made to the claimant, without requiring a request therefor.

(d) For the purposes of this section, a claim, or portion thereof, is reasonably contested if the plan has not received the completed claim. A paper claim from an institutional provider shall be deemed complete upon submission of a legible emergency department report and a completed UB 92 or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the plan within 30 working days of receipt of the claim. An electronic claim from an institutional provider shall be deemed complete upon submission of an electronic equivalent to the UB 92 or other format adopted by the National Uniform Billing Committee, and reasonable relevant

information requested by the plan within 30 working days of receipt of the claim. However, if the plan requests a copy of the emergency department report within the 30 working days after receipt of the electronic claim from the institutional provider, the plan may also request additional reasonable relevant information within 30 working days of receipt of the emergency department report, at which time the claim shall be deemed complete. A claim from a professional provider shall be deemed complete upon submission of a completed HCFA 1500 or its electronic equivalent or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the plan within 30 working days of receipt of the claim. The provider shall provide the plan reasonable relevant information within 10 working days of receipt of a written request that is clear and specific regarding the information sought. If, as a result of reviewing the reasonable relevant information, the plan requires further information, the plan shall have an additional 15 working days after receipt of the reasonable relevant information to request the further information, notwithstanding any time limit to the contrary in this section, at which time the claim shall be deemed complete.

(e) This section shall not apply to claims about which there is evidence of fraud and misrepresentation, to eligibility determinations, or in instances where the plan has not been granted reasonable access to information under the provider's control. A plan shall specify, in a written notice sent to the provider within the respective 30 or 45 working days of receipt of the claim, which, if any, of these exceptions applies to a claim.

(f) If a claim or portion thereof is contested on the basis that the plan has not received information reasonably necessary to determine payer liability for the claim or portion thereof, then the plan shall have 30 working days or, if the health care service plan is a health maintenance organization, 45 working days after receipt of this additional information to complete reconsideration of the claim. If a claim, or portion thereof, undergoing reconsideration is not reimbursed by delivery to the claimant's address of record within the respective 30 or 45 working days after receipt of the additional information, the plan shall pay the greater of fifteen dollars ($15) per each 365-day period, or portion thereof, or interest at the rate of 15 percent per annum, each of these time

periods beginning with the first calendar day after the 30- or 45-working-day period. A health care service plan shall automatically include the fifteen dollars ($15) per each 365-day period, or portion thereof, or the interest due in the payment made to the claimant, without requiring a request therefor. ~~This~~

(g) The obligation of the plan to comply with this section shall not be deemed to be waived when the plan requires its medical groups, independent practice associations, or other contracting entities to pay claims for covered services. This section shall not be construed to prevent a plan from assigning, by a written contract, the responsibility to pay interest and late charges pursuant to this section to medical groups ~~or to~~, independent practice associations*, or other entities when payment of the claim has been delegated to that medical group, independent practice association, or other entity.*

~~(g) (1) A plan shall not assign the responsibility for payment of a claim for emergency services and care to any other entity.~~

~~(2) Notwithstanding paragraph (1), a plan may assign to an independent practice association (IPA) or to a medical group the responsibility for payment of claims for emergency physician services and on-call physician services provided in an emergency department of a hospital if the IPA or medical group submits to the Department of Managed Health Care, on an annual basis, information demonstrating that the IPA or medical group pays these claims on a timely and fair basis. The department shall adopt regulations specifying the standards an IPA or medical group must meet to establish that it pays these claims on a timely and fair basis. In determining whether an IPA or a medical group has met these standards, the department shall solicit and consider information provided by emergency and on-call physicians who are to be paid by the IPA or medical group. The obligation of the plan to comply with this section is not waived if the plan assigns to an IPA or medical group, pursuant to this subdivision, the payment of claims for emergency services and care.~~

~~(3) This subdivision shall not apply to a health care service plan as described in subdivision (f) of Section 1371.4.~~

(h) A plan shall not delay payment on a claim from a physician or other provider to await the submission of a claim from a hospital or other provider, without citing specific rationale as to why the delay was necessary and providing a monthly update regarding the

status of the claim and the plan's actions to resolve the claim, to the provider that submitted the claim.

(i) A health care service plan shall not request or require that a provider waive its rights pursuant to this section.

(j) *This section shall not apply to capitated payments.*

(k) This section shall not be construed to affect the rights or obligations of any person pursuant to Section 1371.

~~(k)~~

(l) This section shall not be construed to affect a written agreement, if any, of a provider to submit bills within a specified time period.

SEC. 2. *Section 1371.4 of the Health and Safety Code is amended to read:*

1371.4. (a) A health care service plan, or its contracting medical providers, shall provide 24-hour access for enrollees and providers to obtain timely authorization for medically necessary care, for circumstances where the enrollee has received emergency services and care is stabilized, but the treating provider believes that the enrollee may not be discharged safely. A physician and surgeon shall be available for consultation and for resolving disputed requests for authorizations. A health care service plan that does not require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition or active labor need not satisfy the requirements of this subdivision.

(b) A health care service plan shall reimburse providers for emergency services and care provided to its enrollees, until the care results in stabilization of the enrollee, except as provided in subdivision (c). As long as federal or state law requires that emergency services and care be provided without first questioning the patient's ability to pay, a health care service plan shall not require a provider to obtain authorization prior to the provision of emergency services and care necessary to stabilize the enrollee's emergency medical condition.

(c) Payment for emergency services and care may be denied only if the health care service plan reasonably determines that the emergency services and care were never performed; provided that a health care service plan may deny reimbursement to a provider for a medical screening examination in cases when the plan enrollee did not require emergency services and care and the

enrollee reasonably should have known that an emergency did not exist. A health care service plan may require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition.

(d) If there is a disagreement between the health care service plan and the provider regarding the need for necessary medical care, following stabilization of the enrollee, the plan shall assume responsibility for the care of the patient either by having medical personnel contracting with the plan personally take over the care of the patient within a reasonable amount of time after the disagreement, or by having another general acute care hospital under contract with the plan agree to accept the transfer of the patient as provided in Section 1317.2, Section 1317.2a, or other pertinent statute. However, this requirement shall not apply to necessary medical care provided in hospitals outside the service area of the health care service plan. If the health care service plan fails to satisfy the requirements of this subdivision, further necessary care shall be deemed to have been authorized by the plan. Payment for this care may not be denied.

(e) A health care service plan may *not* delegate the responsibilities enumerated in this section to ~~the plan's~~ *its* contracting medical ~~providers~~ *provider unless the contracting provider is able to demonstrate to the department an ability to pay claims for these services as provided in Sections 1371, 1371.35, and 1371.37 to both contracting and noncontracting providers of emergency services and care*.

(f) Subdivisions (b), (c), (d), (g), and (h) shall not apply with respect to a nonprofit health care service plan that has 3,500,000 enrollees and maintains a prior authorization system that includes the availability by telephone within 30 minutes of a practicing emergency department physician.

(g) The Department of Managed Health Care shall adopt by July 1, 1995, on an emergency basis, regulations governing instances when an enrollee requires medical care following stabilization of an emergency medical condition, including appropriate timeframes for a health care service plan to respond to requests for treatment authorization.

(h) The Department of Managed Health Care shall adopt, by July 1, 1999, on an emergency basis, regulations governing instances when an enrollee in the opinion of the treating provider

requires necessary medical care following stabilization of an emergency medical condition, including appropriate timeframes for a health care service plan to respond to a request for treatment authorization from a treating provider who has a contract with a plan.

(i) The definitions set forth in Section 1317.1 shall control the construction of this section.

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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